

**Ministerial Review  
of Health Care Networks**

*Interim Report*

**February 2000**



## Ministerial Review of Health Care Networks

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8 February 2000

The Honourable John Thwaites MP  
Minister for Health  
Parliament House  
MELBOURNE VIC 3000

Dear Minister

I attach an Interim Report from the Ministerial Review of Health Care Networks. The Report deals with two key issues:

- proposals for legislation to facilitate disaggregation of the existing networks;
- our current thinking on the optimal configuration of the successor organisations.

The recommendations on legislation should be readily translated into drafting instructions. We have submitted these proposals to you to allow their inclusion in the government's legislative program for the Autumn Session.

There is considerable interest in the health care community about what we might recommend on the new configuration of services in Melbourne. Although we have not finalised our consideration of that issue, public release of our current thinking has a number of benefits:

- it provides an opportunity for the public and providers to give us feedback on those proposals;
- it reduces the scope for speculation and rumour thus allaying unfounded fears;
- it allows us to discuss our proposals in more concrete terms with interested parties to work through implications of our proposals.

Accordingly, we recommend that you release this Interim Report to allow comments to be fed back to us by 3 March 2000.

Yours sincerely

S J Duckett  
Chair

# Table of Contents

**Executive Summary**..... 1

**Reaggregation Options**..... 4

    Background ..... 4

    Criteria for Reaggregation of Agencies..... 5

    Proposed Metropolitan Health Services ..... 11

    Other Issues Relating to Aggregation ..... 13

**Legislative Options**..... 15

    Background ..... 15

    Facilitating Disaggregation of the Networks and the Transition to New Agencies ..... 17

    Key Features of the Proposed Legislation ..... 17

**Please forward any comments on this Interim Report  
by Friday 3<sup>rd</sup> March 2000 to:**

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# Executive Summary

The Ministerial Review of Health Care Networks was established in November 1999 to advise the Minister on establishment of new governance and management structures for metropolitan hospitals, and to identify savings of \$18 million per annum through reductions in the cost of bureaucracy.

The members of the Review Panel are:

- Professor Stephen Duckett, Dean of Health Sciences, La Trobe University (Chair).
- Mr Stan Capp, Chief Executive, Barwon Health.
- Ms Meredith Carter, Director, Health Issues Centre.
- Ms Ella Lowe, Network Director Nursing Services, Peninsula Health Care Network.
- Dr Allan Zimet, John Fawkner Oncology.

The Terms of Reference of the Review are, consistent with Government Policy, to advise Government, no later than March 2000:

- on the optimal future configuration, governance and management arrangements for metropolitan hospitals;
- on mechanisms to ensure coordination of health services, promotion of consumer involvement and promotion of accountability for quality of care in metropolitan hospitals;
- on how recurrent savings of \$18 million per annum can be realised through reduction in network and related bureaucracy, including examination of the role of Departmental metropolitan regional offices; and
- on implementation steps, including required legislative change (if necessary) to achieve the proposed changes.

A public call for submissions to the Review appeared in the press on 4 December 1999 and the closing date for submissions was 21 January 2000. Over 150 submissions have been received by the Review Panel.

This Interim Report summarises the Review Panel's current thinking on the optimal configuration of the successor organisations ("Metropolitan Health Services") to the Health Care Networks. It also outlines proposals for legislation to facilitate the disaggregation of the existing Health Care Networks.

## Proposed Recommendations Relating to Reaggregation

- *The new Metropolitan Health Services should as far as possible be comprehensive, in the sense that they should include acute health, aged care and mental health services.*
- *The new Metropolitan Health Services should have a strong community of interest, including current or potential clinical links, administrative links, academic links and/or historical links. Where agencies identify voluntary alliances these may be given additional weight in determining the new aggregations .*
- *Where services have defined geographic catchments (aged care and mental health) the boundaries of the catchment should, as far as possible, be aligned.*
- *The boundaries of the catchments of the Primary Care Partnerships should also align, as far as possible, with the aged care and mental health catchments.*

- *The financial viability of individual agencies should be carefully considered in the reaggregation of the new Metropolitan Health Services.*
- *The currently preferred option is for the following Metropolitan Health Services:*
  - *Sunshine Hospital/Western Hospital/Williamstown Hospital*
  - *Broadmeadows Health Service/Northern Hospital/Bundoora Extended Care Centre (BECC)*
  - *Royal Melbourne Hospital/Melbourne Extended Care and Rehabilitation Service (MECRS)/Royal Victorian Eye and Ear Hospital*
  - *Alfred Hospital/Caulfield General Medical Centre (CGMC)/Sandringham and District Memorial Hospital*
  - *Angliss Health Service/Box Hill Hospital/Maroondah Hospital/Peter James Centre/Yarra Ranges Health Service*
  - *St Georges Health Service to be auspiced by St Vincent’s Hospital*
  - *Dandenong Hospital/Hampton Rehabilitation Hospital/Kingston Centre/Monash Medical Centre-Clayton/Monash Medical Centre-Moorabbin/Cranbourne Integrated Care Centre*
  - *Austin and Repatriation Medical Centre/Royal Talbot Rehabilitation Centre*
  - *Frankston Hospital/Mt Eliza Aged Care and Rehabilitation Service/Rosebud Hospital*
  - *Royal Children’s Hospital/Royal Women’s Hospital*
  - *Peter MacCallum Cancer Institute*
  - *Dental Health Services Victoria*
- *MonashLink be established as a separate community health centre. This would facilitate aligning the boundaries of this service and the successor to Southern Health Care Network with aged and mental health service boundaries.*
- *Other community health services within the Southern Health Care Network would remain vertically integrated.*
- *The North Western Health Care Network Mental Health Program (with the exception of Central East Mental Health Service) should continue to operate in its current form. Operational responsibility for the service should be located in the aggregation which comprises Sunshine, Western and Williamstown Hospital. The Program should be reviewed after 12 months to ensure there is appropriate coordination of services.*
- *The North West Regional Dialysis Service should continue to operate in its current form. Operational responsibility for the service should be located at Royal Melbourne Hospital. The Program should be reviewed after 12 months to ensure there is appropriate coordination of services.*

## **Proposed Recommendations Relating to Legislation**

- *That legislation be developed to facilitate the disaggregation of the Health Care Networks in a speedy, efficient and cost effective manner and the creation of new ‘successor’ health care agencies along the lines of the proposals outlined in this Interim Report.*
- *The legislation should enable the creation of new public statutory health care agencies known as Metropolitan Health Services. Metropolitan Health Services should be governed by boards. The focus of boards should be good governance in a manner appropriate for public statutory providers of health services.*

- *Boards of Metropolitan Health Services should comprise between 6 and 9 people appointed by the Governor in Council on the recommendation of the Minister.*
- *That the Minister have discretion in recommending appointments to the Governor in Council. Legislation should require the Minister, in recommending appointments, to ensure that -*
  - *each board includes at least one person who is able to reflect the perspectives of users of health services. The legislation should render health service providers ineligible to fulfil this role. Accordingly, registered health practitioners and people currently or recently employed or engaged in the provision of health services should be ineligible for appointment under this particular criterion;*
  - *women and men are adequately represented; and*
  - *no more than 25% of directors can be registered medical practitioners.*
- *That the functions and duties of the board expressed in legislation include to:*
  - *establish the organisational structure of the Metropolitan Health Service;*
  - *appoint the CEO and approve the senior management structure [Note: the legislation should enable the initial CEOs to be appointed by Government on an interim basis];*
  - *oversee the management of the Metropolitan Health Service by the CEO;*
  - *develop a strategic plan consistent with any guidelines produced by the Minister for Health from time to time;*
  - *develop plans, strategies and budgets to ensure the accountable and efficient provision of health services by the Metropolitan Health Service;*
  - *develop collaboration arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care;*
  - *ensure effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the Metropolitan Health Service;*
  - *ensure that any problems identified with the quality or effectiveness of health services are addressed in a timely manner;*
  - *monitor the performance of the Metropolitan Health Service and the CEO; and*
  - *establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served by the Metropolitan Health Service, and that the views of users of health services are taken into account.*
- *The board of a Metropolitan Health Service should be required to establish a community advisory committee and a primary care and population health advisory committee. The board should have the capacity to establish such other committees as it determines.*
- *Legislation should provide for the establishment of new stand alone community health centres with appointed boards as an interim measure.*
- *Legislation should, as far as possible, facilitate the transfer of Network staff to new 'successor' entities, on the same terms and conditions of employment and with continuity of service.*
- *Legislation should enable Metropolitan Health Services to benefit from trusts in favour of the former (pre-Network era) public hospitals and require, so far as possible, that trust moneys be applied at the corresponding campus/premises.*
- *Legislation should facilitate the creation of Health Services Support Agencies.*

# Reaggregation Options

## Background

One of the major aims of aggregation is to facilitate the integration of health services, achieve economies of scale and allow more localised, detailed and rational planning of a range of services for a given community. There are a number of models of aggregation ranging from loose alliances, affiliations and joint ventures to amalgamations and mergers (MHPB, 1995: 41). The current Network arrangements in Victoria are based on the amalgamation model, whereby a single board is established and is responsible for the operation of an entire amalgamated health service.

In January 1995 the then Government released *Victoria's Health to 2050*. This document identified the need for major change in the provision of acute health care services to meet the future health service needs of the community. It recommended the establishment of a Metropolitan Hospitals Planning Board to develop a plan for metropolitan hospital services in the future. The Metropolitan Hospitals Planning Board (MHPB) was duly established in February 1995 and in June 1995 recommended the formation of seven Health Care Networks based on the 35 independent public hospitals in Melbourne. This recommendation was accepted by the then Government and the Networks, under newly-appointed Boards, commenced operation on 1 August 1995.

Since the Networks were created the following changes have occurred:

19 December 1995	Dental Health Services Victoria created as a Network under the Health Services Act.
1 July 1996	Inner and Eastern Health Care Network created following the amalgamation of the Inner Health Care Network and the Eastern Health Care Network.
30 September 1997	The Southern Health Care Network amalgamated with five community health centres.
3 November 1997	Health Care Network created following the amalgamation of the North Eastern Health Care Network and Western Health Care Network.
3 November 1997	atriation Medical Centre was assigned a status equivalent to a Network. The Royal Talbot Rehabilitation Centre became an agency of the Austin & Repatriation Medical Centre.

## Metropolitan Hospitals Planning Board Recommendations

The MHPB vision was that the new networks would oversee the gradual transfer of many services from inner Melbourne to the middle and outer suburbs of the city. Each network would offer a range of services and ideally networks should incorporate aged, psychiatric, palliative, rehabilitation and home-based services to facilitate the continuity of care between home and hospital. The new networks were intended to be Boards of Governance rather than Boards of Management, and were to be governed by professional directors and managed by professional managers, including clinical managers (MHPB, 1995).

In correspondence to the Review, Professor Ian Harper the former Chair, and Professor Peter Phelan, a former member of the Metropolitan Hospitals Planning Board, indicate that the Southern Health Care Network, the Women's and Children's Health Care Network and the Peninsula Health Care Network are the only Networks which now exist as originally envisaged by the Board. They suggest that in terms of managing networked hospital services in particular, these Networks are the closest to achieving the goals of networking.

Professors Harper and Phelan advise that the North Western Health Care Network and the Inner and Eastern Health Care Network are much larger than was intended by the MHPB and do not easily cover a geography that lends itself to a community focus. In addition, they maintain that each Network should continue to contain a tertiary hospital and that this will contain unnecessary growth in tertiary services and direct more general services closer to where people live. Finally, they suggest that the failure of the Government to establish a planning authority to review Network plans, consider cross Network issues and monitor performance may be one reason for some of the duplication that now exists.

## **Reform of Primary Health**

During 1999 considerable resources were put into efforts to improve the functioning of primary health and community support services by the Department of Human Services and a wide range of service providers and peak bodies. Since the election of the new Government, an independent review of the primary health redevelopment efforts was undertaken by Adjunct Professor Hayden Raysmith. Professor Raysmith's report was delivered to Ministers on 29 December 1999 and contains a number of relevant recommendations.

The Review recommended that:

- The development of proposed Primary Care Partnerships based on collaborative alliances of relevant service providers (with consumer/carer input) proceed but with a clear focus on planning and service coordination.
- That the alliances based on previously identified catchments (based on local government boundaries) be maintained, subject to a small number of potential variations, based on identified criteria.

## **Criteria for Reaggregation of Agencies**

The larger the size of the Network structure increases the likelihood that a second tier of administration and bureaucracy will be introduced. This is evident in the case of both the Inner and Eastern Health Care Network and the North Western Health Care Network. However, there are also clear benefits in terms of increased economies of scale and the potential for greater coordination of services.

The Government has stated that it favours a model which would see smaller groups of hospitals and other agencies working in local partnerships across sectors such as hospital, aged care and mental health. The existing Women's and Children's Health Care and Peninsula Health Care Networks have been identified as being of an appropriate size.

The new Metropolitan Health Services should be strongly community focused and a return to individual boards for every hospital or agency within the service is not recommended. In addition, they should be of a size that achieves the best clinical outcomes, reduces unnecessary clinical and administrative duplication and have an identifiable community of interest. The community of interest may be a geographical community, a tertiary role, a specialist focus or specific populations such as women or children. Financial viability is also an important consideration in determining the make-up of the new Metropolitan Health Services.

## Size of Groupings

The current Networks vary considerably in terms of number of agencies included, size of budget and levels of activity. Table 1 details the number of agencies in each Network.

It can be seen that ARMC, Peninsula and Women's and Children's Health Care Networks are almost identical in terms of the composition of agencies, with the exception of the inclusion of community health services in the Peninsula Network. Again, the Inner and Eastern and North Western Health Care Networks are significantly larger.

**Table 1: Number of Campuses in Each Network, 1999/2000\***

<i>Network</i>	<i>Acute Campuses</i>	<i>Integrated Care Centres</i>	<i>Rehab/Extended Care/Aged Care</i>	<i>Community Health Centres</i>
Peninsula HCN	2		1	1
Women's & Children's HCN	2			
<u>Other Networks</u>				
Inner and Eastern HCN	7		3	1
North Western HCN	5	1	2	
Southern	4	1	2	6
ARMC	2		1	

\* This table does not include hostels, nursing homes, drug and alcohol programs, needle exchange programs, community rehabilitation centres and other services located on the site of the major campuses.

Table 2 shows the total 1998/99 operating expenditure for each Network, the Acute Health budget and WIES throughput targets for 1999/2000.

**Table 2: Total Operating Expenditure, Acute Health Budget and Throughput, 1998/99**

<i>Network</i>	<i>Acute Health Expenditure Budget (\$M)</i>	<i>Total WIES6 (Target)</i>	<i>Total Operating Expenditure (\$M)</i>	<i>Entity Expenditure (\$M)</i>
Peninsula HCN	\$83.1	30,959	\$125.8	\$129.8
Women's & Children's HCN	\$170.1	49,870	\$229.1	\$284.5
<u>Other Networks</u>				
Inner and Eastern HCN	\$450.5	124,249	\$610.5	\$640.4
North Western HCN	\$382.7	122,472	\$575.3	\$603.8
Southern	\$272.9	85,445	\$373.3	\$449.7
ARMC	\$199.1	54,043	\$257.4	\$285.9
<u>Denominational Hospitals</u>				
St Vincent's Hospital	\$137.5	35,286	\$199.4	n/a

Source: Network Annual Reports, 1998/99; Victoria-Public Hospitals Policy and Funding Guidelines, 1999/2000.

The Peninsula Health Care Network, the Women's and Children's Health Care Network and the Austin & Repatriation Medical Centre have significantly lower total operating expenditure budgets and Acute Health budgets than other Networks. This is particularly evident for the Inner and Eastern Health Care Network and North Western Health Care Network which have budgets between two and three times higher than the smaller Networks.

The Minister, in announcing the Review, indicated that the Government favoured a model which would see smaller groups of hospitals and other agencies working in partnership across sectors such as hospital, aged care and mental health. Further, he indicated that the new entities would be about the size of the existing Women's & Children's Health Care

Network and the Peninsula Health Care Network. The data above shows that the Austin and Repatriation Medical Centre and St Vincent's Hospital are currently of a similar size to these two Networks. The recommended new Metropolitan Health Services are based on establishing groups of agencies of the size of those outlined above.

**Proposed Recommendation:**

- *The new Metropolitan Health Services should as far as possible be comprehensive, in the sense that they should include acute health, aged care and mental health services.*

**Community of Interest**

Improving the clinical and administrative links between providers was a key objective leading to the establishment of the Health Care Network arrangements. It was envisaged that the Network model would re-group existing facilities in a way which “promotes the development of a seamless system of health care delivery” (MHPB, 1995: p. v). The degree to which this has been achieved varies across Health Care Networks. Information was sought from Networks on the extent of their clinical, administration, academic and historical links between agencies within their Network.

**Proposed Recommendation:**

- *The new Metropolitan Health Services should have a strong community of interest, including current or potential clinical links, administrative links, academic links and/or historical links. Where agencies identify voluntary alliances these may be given additional weight in determining the new entities.*

**Geographic Homogeneity**

The Network arrangements proposed by the MHPB, and established in 1995, originally comprised seven provider networks. Five of these networks were geographically based and two had a more specialist focus. The five geographically based networks incorporated community hospitals, a major tertiary referral hospital, an extended care centre and mainstreamed psychiatric services. The exception to this was the Peninsula Network which does not include a tertiary centre.

The two specialist networks were the Specialist Network incorporating the Royal Women's Hospital and the Royal Children's Hospital, and the Inner Network incorporating Peter MacCallum Cancer Institute, Royal Victorian Eye and Ear Hospital, St Vincent's Hospital, Bethlehem Hospital, Caritas Christi Hospice and the then St Georges Hospital and Inner East Geriatric Service (now the St Georges Health Service).

The subsequent merger of the Inner Network and the Eastern Network and the North Eastern Network with the Western Network resulted in two Networks which are much larger than was originally intended by the MHPB. As such they do not easily cover a geography that lends itself to a community focus. Table 3 shows the longest travel times between hospitals within the current Networks.

**Table 3: Travel Times Between Hospitals by Network**

<i>Network</i>	<i>Longest Travel Time</i>	<i>Inpatient Agencies</i>
Peninsula HCN	40 mins	Frankston↔Rosebud
Women's & Children's HCN	5 mins	RCH↔RWH
<u>Other Networks</u>		
Inner and Eastern HCN	76 mins	Yarra Ranges↔CGMC
North Western HCN	50 mins	Williamstown↔BECC/Northern
Southern	29 mins	Hampton↔Dandenong
A&RMC	15 mins	Austin/Repat↔Royal Talbot

The large size of the Inner and Eastern and North Western Health Care Networks are demonstrated by the travel times shown above. The time taken to travel between Caulfield General Medical Centre and the Yarra Ranges Health Service located in Healesville is 76 minutes, while the longest “off peak” travel times between agencies in the North Western Health Care Network is 50 minutes between Williamstown Hospital and both the Bundoora Extended Care Centre and the Northern Hospital located in Epping.

### **Catchment Areas for Aged, Community & Mental Health Services**

The Commonwealth and State fund a large number of organisations in the public, private and voluntary sectors to deliver a diverse range of health and community services in metropolitan Melbourne. These services range from highly targeted services that operate on a local, regional/sub-regional or Statewide basis through to untargeted services that are available on local, regional/sub-regional or Statewide basis. There are also varying levels of non-publicly funded service provision. The availability of non-publicly funded service provision for particular services varies significantly on a geographic basis.

The Metropolitan Health Care Networks are significant providers of a wide range of services funded by the Aged, Community and Mental Health (ACMH) Division of the Department of Human Services. They also auspice a range of Commonwealth and joint Commonwealth/State funded services targeted to meet the needs of people within their areas of operation.

#### ***Mental Health Services***

Metropolitan Health Care Networks are the major providers of publicly funded mental health services in the metropolitan area. In most metropolitan Department of Human Service (DHS) Regions, Networks are the sole providers of publicly funded mental health services. DHS funded services are broken into three broad streams - Child and Adolescent, Adult, and Aged. Some Networks also auspice specific publicly funded mental health services on a statewide basis (e.g. Royal Melbourne Hospital/North Western Health Care Network - Neuropsychiatry).

DHS funded mental health services are managed and funded on an area basis through Area Mental Health Services (AMHS). AMHS are required to provide services to the population within each designated catchment area. 11 of the 13 AMHS in the metropolitan area are auspiced by Health Care Networks who provide acute inpatient, residential, and community based services through a range of service outlets in defined catchments areas. The two exceptions being the Inner East AMHS (auspiced by St Vincent's Hospital) which covers the LGAs of Yarra and Boorandara and the South West AMHS (auspiced by the Mercy Hospital Werribee) which covers the LGAs of Maribyrnong, Wyndham, & Hobsons Bay.

While most AMHS are based on current LGA boundaries there are a number which remain based on old LGA boundaries. AMHS boundaries generally do not align with ACAS catchments or proposed Primary Care Partnership (PCP) boundaries. Some AMHS boundaries do not align with current LGA boundaries and/or DHS Regional boundaries. In addition, there is one situation where mental health services for a significant part of the Eastern Metropolitan Region are provided from service outlets that form part of the Inner and Eastern Health Care Network but are auspiced by the North Western Health Care Network.

### ***Aged Care Assessment Services (ACAS)***

There are 10 Aged Care Assessment Services (ACAS) operating in the metropolitan area, all of which are auspiced by Health Care Networks. Each geographically based Network auspices at least one ACAS. Most ACAS are located at one of the metropolitan Extended Care Centers which provide a wide range of services primarily targeted at needs of older people (Sub-acute services, Palliative Care, Psychogeriatric Care, Clinics, residential care etc). While the Commonwealth Department of Health and Aged Care and DHS revised ACAS catchments in 1995 so that they aligned with local government areas, several anomalies still exist.

In the event that ACAS catchments are realigned, the following Commonwealth ACAS Program requirements will require consideration:

- The allocation of State and Commonwealth funds. Currently, ACAS Commonwealth funds are allocated according to the proportion of 70+ population within the catchment area.
- ACAS Management arrangements (if catchment numbers change).
- Management and allocation of ACAS delegations.
- Collection of ACAS Minimum Data Set (MDS).

Further issues to be considered include:

- Some Networks auspice ACAS with catchment areas that include facilities of other Networks (e.g. Kingston ACAS).
- In most cases ACAS boundaries cross proposed Primary Care Partnership (PCP) boundaries.
- Most ACAS boundaries do not align with Area Mental Health Service/Psychogeriatric Assessment and Treatment (PGAT) service boundaries.
- ACAS catchment areas for funding purposes need to be agreed by both the Commonwealth and State.

### ***Home and Community Care (HACC) Linkages***

There are 2 metropolitan Home and Community Care (HACC) Linkages Services currently auspiced by metropolitan Health Care Networks. All other HACC Linkages services are auspiced by non-government agencies and operate within defined catchment areas.

### ***Community Health Centres***

Community Health Centres operate throughout Victoria and deliver a wide range of services funded primarily by the ACMH and Public Health Divisions of DHS. In three of the metropolitan Health Care Networks, one or more Community Health Centres have been integrated into the Network structure. The greatest level of integration occurred with the amalgamation of the Southern Health Care Network and six community health centres on 30 September 1997. One Community Health Centre has integrated with the Peninsula

Health Care Network and another has integrated with the Inner and Eastern Health Care Network. There are currently 22 independent Community Health Centres with Boards of Management in the metropolitan area.

### ***Primary Health Boundaries***

The future shape of Primary Care Partnership (PCP) boundaries proposed by the recent Review of Primary Health Redevelopment is relevant to consideration of catchment issues. Apart from the question of interrelationships between acute and primary health services, the future directions for PCP boundaries will be relevant to those PCP services currently auspiced by Networks (in particular ACAS, Centres Against Sexual Assault (CASA), and HACC). PCP catchments use LGAs as a “building block” and best representation of local communities of interest.

There are compelling reasons to strive for greater alignment of key primary care service catchments. If this can be achieved, it should influence the formation of the new Metropolitan Health Services. The maximisation of alignment of primary care catchments and reaggregation of Health Care Networks and the development of mechanisms and structures to achieve integrated population health planning, service planning and service delivery should be key objectives.

Potential advantages of maximising the alignment of reaggregated Health Care Networks with streamlined primary health catchments include:

- Improved local and sub-regional planning processes to identify and address the health needs of the catchment population;
- Potential for improved communication and service links between primary, residential and tertiary providers within identified catchments. This should improve planning for and delivery of integrated, seamless services for individuals (improved *quality*) e.g. discharge planning and delivery of post-acute care;
- Improved capacity to optimise service distribution and flexibility within a single catchment. This has potential to improve the *access* of people within the catchment area to appropriate services.

### **Proposed Recommendation:**

- *Where services have defined geographic catchments (aged care and mental health) the boundaries of the catchment should, as far as possible, be aligned.*
- *The boundaries of the catchments of the Primary Care Partnerships should also align, as far as possible, with the aged care and mental health catchments.*

## **Financial Viability**

The financial performance of Networks is currently monitored by the Department of Human Services on an network-wide basis. Information on the financial position of each individual agency (including surplus/deficit situation and liquidity) has been sought and will be an important consideration in the reaggregation of agencies. Further assessment of the viability of the proposed aggregations is currently underway.

### **Proposed Recommendation:**

- *The financial viability of individual agencies should be carefully considered in the reaggregation of the new Metropolitan Health Services.*

## Proposed Metropolitan Health Services

Most of the submissions received by the Review made proposals for new aggregations of services. These proposals have been considered by the Review Panel and evaluated against the general principles and criteria for aggregating services outlined earlier. More detailed work is being undertaken by the Review Panel to evaluate these proposals including consequential impacts on existing shared services. The Review Panel has not yet finalised its desired aggregations and, in particular, has not finalised its review of the financial viability of each aggregation nor the proposed mental health and aged care catchments. The currently preferred option is for the following aggregations:

- **Sunshine Hospital/Western Hospital/Williamstown Hospital**

The majority of submissions commenting on hospitals within the North Western Health Care Network supported this reaggregation of hospitals. There were some variations on these aggregations with one submission recommending a Western Hospital and Williamstown Hospital aggregation.

- **Broadmeadows Health Service/Northern Hospital/Bundoora Extended Care Centre (BECC)**

This aggregation was also strongly supported. Two submissions recommended that Broadmeadows Health Service be aggregated with Royal Melbourne and MECRS. The assignment of BECC to this aggregation will be reviewed in light of the proposed catchment areas for aged care and mental health. The Integrated Care Centre proposed for Sunbury would also fit within this aggregation.

- **Royal Melbourne Hospital/Melbourne Extended Care and Rehabilitation Service (MECRS)/Royal Victorian Eye and Ear Hospital**

A number of submissions supported the aggregation of Royal Melbourne Hospital and the Melbourne Extended Care and Rehabilitation Service (MECRS).

There were a variety of proposals for the Royal Victorian Eye and Ear Hospital. The Review Panel considered four options: stand alone; aggregation with Peter MacCallum Cancer Institute; aggregation of all Specialist Hospitals; and aggregation with either Royal Melbourne Hospital or St Vincent's Hospital. On balance the preferred option is for aggregation with the Royal Melbourne/MECRS group. Arrangements relating to the ownership of assets, protection of the integrity of funds donated to the Royal Victorian Eye and Ear Hospital for specific purposes for example, will need to be addressed if this aggregation is accepted.

- **Alfred Hospital/Caulfield General Medical Centre (CGMC)/Sandringham and District Memorial Hospital**

In general, the submissions commenting on hospitals within the Inner and Eastern Health Care Network supported the reaggregation of hospitals into the three groupings presented here. A number of submissions commented that the Alfred Hospital/CGMC aggregation needed to ensure appropriate linkages with Bethlehem Hospital were maintained. In addition, there was support for grouping Sandringham and District Memorial Hospital with the Alfred Hospital and the CGMC.

- **Angliss Health Service/Box Hill Hospital/Maroondah Hospital/Peter James Centre/Yarra Ranges Health Service**

There were several variations on the grouping of hospitals in the eastern metropolitan area, with some submissions supporting smaller aggregations (i.e. Angliss and Maroondah including or excluding Yarra Ranges Health Service). One submission recommended that Yarra Ranges Health Service be classified as a rural hospital and be removed from the metropolitan arrangements.

- **St Georges Health Service to be auspiced by St Vincent's Hospital**

It is proposed that the services of St Georges Health Service be auspiced by St Vincent's Hospital, which would remain a denominational hospital but would otherwise have the attributes of a 'Metropolitan Health Service' in terms of breadth of services (acute, aged care, mental health services) etc. There was support for the aggregation of St Vincent's Hospital and St Georges Health Service, including support from both agencies. This proposed aggregation would be predicated on a redistribution of palliative care services from Caritas Christi to enable expansion of services to be auspiced by Angliss Hospital/Box Hill Hospital/Maroondah Hospital/Peter James Centre/Yarra Ranges Health Service. St. Vincent's Hospital currently provides a range of correctional health services so it would be appropriate to develop closer links between the new St. Vincent's Hospital aggregation and the Victorian Institute for Forensic Health.

- **Dandenong Hospital/Hampton Rehabilitation Hospital/Kingston Centre/Monash Medical Centre-Clayton/Monash Medical Centre-Moorabbin/Cranbourne Integrated Care Centre**

A large number of submissions argued for the retention of the Southern Health Care Network, and in particular that Dandenong Hospital should not be separated from other hospitals in the Network. A smaller number of submissions recommended splitting the Network into two, with Dandenong Hospital and the Cranbourne Integrated Care Centre in one group and the remaining hospitals in the other.

The submissions arguing for a split in the Network drew attention to perceived poor morale at Dandenong Hospital, centralisation of decisions at Monash Medical Centre-Clayton and relative underfunding of services at Dandenong. These perceptions are clearly issues that need to be addressed. However, the Review Panel believes that the benefits of the clinical integration across the hospitals in the Network outweigh their negatives, hence the recommendation of the Panel. From the Panel's meetings at Dandenong, it appears that this assessment of relative benefits and costs is widely held (but not unanimously) at Dandenong Hospital.

- **Austin and Repatriation Medical Centre/Royal Talbot Rehabilitation Centre**

This aggregation is unchanged from the existing Austin and Repatriation Medical Centre (ARMC). The submissions indicated divided support for the inclusion of Bundoora Extended Care Centre within this aggregation. There was also some support for including Northern Hospital in a ARMC/BECC aggregation.

- **Frankston Hospital/Mt Eliza Aged Care and Rehabilitation Service/Rosebud Hospital**

This aggregation is unchanged from the existing Peninsula Health Care Network.

- **Royal Children’s Hospital/Royal Women’s Hospital**

This aggregation is unchanged from the existing Women’s and Children’s Health Care Network. It was argued to the Review Panel that the identity and profile of women’s health services have been diminished following the establishment of the Network. These perceptions are clearly issues that need to be addressed.

- **Peter MacCallum Cancer Institute**

There were a number of submissions supporting stand alone arrangements for Peter MacCallum Cancer Institute under establishment of its own Board of Directors. Several other submissions proposed the establishment of a Specialist Group which would include Peter MacCallum, Royal Victorian Eye and Ear Hospital, Royal Children’s Hospital and Royal Women’s Hospital.

- **Dental Health Services Victoria**

This aggregation is unchanged from the existing Dental Health Services Victoria Network.

## Other Issues Relating to Aggregation

### Community Health Centres

There was mixed support for the inclusion of community health centres within the new aggregations.

**Proposed Recommendation;**

- *MonashLink be established as a separate community health centre. This would facilitate aligning the boundaries of this service and the successor to Southern Health Care Network with aged and mental health service boundaries.*
- *Other community health services within the Southern Health Care Network would remain vertically integrated.*

### North Western Health Care Network Mental Health Program

A number of submissions supported the retention of the North Western Health Care Network Mental Health Program as a regional service, with the exception of Central East Mental Health Service which should become part of the Angliss/Box Hill/Maroondah/Peter James Centre/Yarra Ranges Health Service aggregation. The Review Panel acknowledges the success of this Program and proposes that it continue to operate in its current form.

**Proposed Recommendation:**

- *The North Western Health Care Network Mental Health Program (with the exception of Central East Mental Health Service) should continue to operate in its current form. Operational responsibility for the service should be located in the aggregation which comprises Sunshine, Western and Williamstown Hospital. The Program should be reviewed after 12 months to ensure there is appropriate coordination of services.*

## North West Regional Dialysis Service

There was also strong support for the retention of the North West Regional Dialysis Service. Similar arrangements are proposed whereby this service would continue to operate in its current form, with operational responsibility for the service located at Royal Melbourne Hospital. The Program should be reviewed after 12 months to ensure there is appropriate coordination of services.

### **Proposed Recommendation:**

- *The North West Regional Dialysis Service should continue to operate in its current form. Operational responsibility for the service should be located at Royal Melbourne Hospital. The Program should be reviewed after 12 months to ensure there is appropriate coordination of services.*

## Relations with Denominational and Privately Operated Public Hospitals

There is a need to develop mechanisms to ensure appropriate links between public hospitals and denominational hospitals and any privately operated public hospitals are maintained.

# Legislative Options

## Background

The Review Panel considers that changes to the Health Services Act 1988 would be useful to facilitate the speedy and efficient disaggregation of the Health Care Networks and the creation of new smaller groupings of metropolitan public health services as outlined above.

Following consideration of the submissions received, the Review Panel has developed initial proposals for legislative change. These proposals have been developed in light of the Government's desire to:-

- implement speedy change with no disruption to the provision of health services and the minimal possible impact on staff morale and;
- ensure that public health care agencies are accountable and responsive to their communities and the Government (as agent for the people of Victoria);
- foster effective governance of public health care agencies (including ensuring that boards and CEOs are accountable for the quality, efficiency and effectiveness of health services provided);
- enable meaningful consumer/community input to assist the deliberations of the boards and CEOs of the new public health care agencies; and
- foster efficiency by minimising expenditure on corporate resources in public health care agencies.

## About the Health Services Act 1988

The Health Services Act 1988 is an important policy instrument. It provides the statutory framework for the funding and regulation of health care networks, public hospitals and other publicly funded health care agencies and the regulation of the private hospital sector. It creates Health Care Networks and public hospitals as incorporated public statutory bodies and provides for their governance arrangements, functions and powers. It also provides for the governance of community health centres. The Act contains various controls over publicly funded health care agencies which aim to ensure that public funds are used effectively for the provision of health services which meet the community's needs, and that health care agencies are accountable for the use of public money.

The objectives of the Act, as set out in section 9, are to make provision to ensure that -

- a) health services provided by health care agencies are of a high quality;
- b) an adequate range of essential health services is available to all persons resident in Victoria irrespective of where they live or whatever their social or economic status
- c) public funds -
  - are used effectively by health care agencies; and
  - are allocated according to need;
- d) health care agencies are accountable to the public;

- e) users of health services are provided with sufficient information in appropriate forms and languages to make informed decisions about health care;
- f) health care workers are able to participate in decisions affecting their work environment; and
- g) users of health services are able to choose the type of health care most appropriate to their needs.

The Review Panel has taken into account the Act's existing objectives in developing the proposals for legislative change in this interim report.

## **Assumptions about changes to legislation**

Any legislative changes to facilitate the disaggregation and transition to new agencies will need to reflect the desired policy outcomes. The Review Panel envisages that -

- there will be few major changes to the way in which health services are delivered. In most cases, people currently working at a campus of a Network will continue to have the same job at the same location. The vast majority of staff will transfer to equivalent jobs on the same terms and conditions of employment, and with continuity of service
- four existing Networks – the Peninsula Health Care Network, the Women's and Children's Health Care Network and the Austin and Repatriation Medical Centre together with Dental Health Services Victoria (which is technically a Network) will remain intact
- in some cases, where community health centres have been amalgamated with Networks and now form part of Networks, stand alone community health centres will be re-established and relevant property and staff will be transferred to the newly formed CHCs
- it is desirable to ensure that any of the benefits of the Networks (including common support services which yield economies of scale) continue.

## **About Health Care Networks**

In 1995, specific amendments to the Health Services Act were enacted to facilitate the aggregation of public hospitals to form Networks and to provide for the governance, powers and functions of the Networks.

Each Network is a single incorporated public statutory body which is the successor in law of all of the former public hospitals which were aggregated to form it. Each Network is governed by a board of directors comprising 6-9 people appointed by the Governor in Council on the recommendation of the Minister for Health. There are currently no specific criteria in the Act to guide the Minister in making appointments to the board. However, the board must be capable of fulfilling its statutory functions.

## **How were Health Care Networks created?**

The principal statutory mechanism used to create the Networks was Governor in Council Orders which also provided for the appointment of initial boards of governance and CEOs. Other provisions inserted into the Act by the 1995 amendments ensured that, on the date specified in such an Order, all property, rights, assets and liabilities of the former public

hospitals that were aggregated to form a Network were transferred to the Network without the need for conveyances, deeds or other legal instruments to effect the transfer. Specific provisions were also included in the Act to facilitate the transfer of former public hospital staff to the new Networks and to enable the Network to benefit from trusts in favour of the former public hospitals, according to the tenor of the trust (this is explained in more detail below).

## **Facilitating Disaggregation of the Networks and the Transition to New Agencies**

The process of disaggregating existing Networks is not as straightforward as the process of creating them because Network assets and liabilities will need to be divided and, as far as possible, allocated to various identified public health care agencies.

The Government has indicated that it wishes to achieve disaggregation by 1 July 2000. In order to meet the Government's timetable for change, it will be necessary to identify key assets and liabilities essential for the provision of health services (e.g. hospital premises, plant and equipment, staff and records) which are capable of being transferred quickly to designated health care agencies.

Just as Orders in Council operated to facilitate the creation of the Networks and the transfer of assets and liabilities to them in a speedy and efficient manner, new legislation could provide for the making of Orders which facilitate the disaggregation process and the transition to new entities. This approach is preferred by the Review Panel because it minimises the need for legal transactions and expenditure, and creates greater certainty for Network staff and those involved in business relationships with current Networks.

The Panel also considers legislation to be desirable because it would enable the creation of new public statutory health service providers in the metropolitan area with boards and governance provisions which more closely reflect the Government's policy directions and contemporary thinking about clinical governance.

The Victorian Healthcare Association's submission has suggested that one option is to create the successor agencies to the Networks as public hospitals under the Health Services Act. This approach is not preferred. It would preclude the opportunity to strengthen the governance arrangements of the newly created public health care agencies, as the Review Panel's terms of reference do not encompass a review of rural public hospitals. Further, this approach could give rise to perceptions that the proposals for change in this report embody a return to the pre-Networks era, instead of structural changes designed to ensure public health services are equipped to meet future needs and challenges. It could also cause confusion between pre-existing public hospitals and the new entities.

## **Key Features of the Proposed Legislation**

The Panel proposes that legislation would enable the creation of new legal entities to be known as Metropolitan Health Services and the creation of some new stand alone community health centres by Order in Council and the transfer of identified assets and liabilities to them. Orders could provide for the establishment of initial boards and appointment of interim CEOs who would assume office on a specified date. Such legislation

should also facilitate the transfer of Network staff to the new entities on their existing terms and conditions of employment and with continuity of service as far as possible.

If necessary, once Metropolitan Health Services are created, administrators could be appointed to the Networks (where they continue to exist as legal entities). The role of an administrator would be to work with boards of the new entities and other relevant parties to resolve any unresolved issues about the allocation and transfer of assets and liabilities. The administrators would eventually wind up the remaining Networks once these matters are settled.

The Panel does not propose the disaggregation of the Peninsula Health Care Network, the Women's and Children's Health Care Network, the Austin and Repatriation Medical Centre or Dental Health Services Victoria. In these circumstances, the Panel envisages that newly created Metropolitan Health Services would become the successors in law of these Networks, with new boards. It is desirable to recreate them as new Metropolitan Health Services in order to ensure that their governance arrangements reflect current policy and are consistent with the other Metropolitan Health Services, and so that the provisions of the Health Services Act with respect to Networks can ultimately be repealed once the Networks are wound up.

**Proposed Recommendation:**

- *That legislation be developed to facilitate the disaggregation of the Health Care Networks in a speedy, efficient and cost effective manner and the creation of new 'successor' health care agencies along the lines of the proposals outlined in this Interim Report.*

## **New Public Statutory Bodies—Metropolitan Health Services**

The Panel proposes that the legislation create Metropolitan Health Services as incorporated public statutory bodies which are not part of, and do not represent, the Crown.

Like public hospitals and Health Care Networks, Metropolitan Health Services would be *registered funded agencies*, subject to the existing provisions of the Health Services Act which apply to public hospitals and Networks, except for those which provide for the establishment of public hospitals and Networks and the appointment, powers and functions of Network and public hospital boards.

Accordingly, existing statutory provisions with respect to matters such as health service agreements, casemix auditing, quality assurance and confidentiality and existing statutory controls such as the Secretary's powers of direction under s.42 would apply to Metropolitan Health Services.

### ***Metropolitan Health Services - Composition of Boards***

It is proposed that Metropolitan Health Services would be governed by boards of directors comprising between 6 and 9 people appointed by the Governor in Council on the recommendation of the Minister for Health.

Many submissions to the Review have emphasised the need for structures which foster good governance of public health care agencies. The Review Panel agrees that this is important. It believes that focus of boards of Metropolitan Health Services should be good governance, in a manner appropriate for public statutory providers of health services.

**Proposed Recommendation:**

- *The legislation should enable the creation of new public statutory health care agencies known as Metropolitan Health Services. Metropolitan Health Services should be governed by boards. The focus of boards should be good governance in a manner appropriate for public statutory providers of health services.*
- *Boards of Metropolitan Health Services should comprise between 6 and 9 people appointed by the Governor in Council on the recommendation of the Minister.*

It is proposed that the Minister have discretion in making recommendations to the Governor in Council. However, numerous submissions to the review have emphasised the need for consumers' needs and preferences to be considered in the decision making process of health care organisations. To assist in achieving this, the Panel considers that the legislation should require the Minister, in making recommendations, to ensure that each board includes at least one person who is able to reflect the perspectives of users of health services. The legislation should render current health service providers ineligible to fulfill this role. Accordingly, registered health practitioners and people currently or recently employed or engaged in the provision of health services should be ineligible for appointment under this particular criterion.

To ensure that the composition of boards is balanced, the Panel proposes that, as is currently the case for public hospitals under the Health Services Act, the legislation should require the Minister to ensure that -

- women and men are adequately represented; and
- no more than 25% of directors can be registered medical practitioners.

A number of submissions have proposed that the boards of new 'successor' agencies should include people drawn from specified professions or nominated by specified organisations. However, the Panel considers that legislation should not be prescriptive about the process for selecting candidates and should not require nominations from any particular organisation, as this could potentially constrain the Government's capacity to select the best candidates possible and ensure that the overall composition of each board is well balanced.

Instead, administrative guidelines published from time to time could outline the process for attracting prospective candidates. A variety of strategies can be adopted to ensure the best candidates possible. For instance, there could be public advertising for prospective directors, boards or organisations could be invited to submit names for consideration or individuals with relevant skills, expertise and a commitment to serving the public on a Metropolitan Health Service board could be approached directly.

**Proposed Recommendation:**

*That the Minister have discretion in recommending appointments to the Governor in Council. Legislation should require the Minister, in making recommendations, to ensure that:-*

- *each board includes at least one person who is able to reflect the perspectives of users of health services. The legislation should render health service providers ineligible to fulfil this role. Accordingly, registered health practitioners and people currently or recently employed or engaged in the provision of health services should be ineligible for appointment under this particular criterion;*
- *women and men are adequately represented; and*
- *no more than 25% of directors can be registered medical practitioners.*

## ***Functions and Duties of Boards***

The Review Panel considers that the functions and duties of boards of Metropolitan Health Services should include appropriate duties of Network boards, such as the duty to develop plans, strategies and budgets and to monitor the performance of the organisation and the CEO. However, the current undue emphasis on 'commercial' viability should be replaced by a more balanced requirement for sound financial management and accountability. The Panel considers that this more accurately reflects the true nature of Metropolitan Health Services as public statutory bodies whose core purpose is to provide services to public patients in accordance with the Medicare principles.

### **Proposed Recommendation:**

*That the functions and duties of the board expressed in legislation include to:*

- *establish the organisational structure of the Metropolitan Health Service;*
- *appoint the CEO and approve the senior management structure [Note: the legislation should enable the initial CEOs to be appointed by Government on an interim basis];*
- *oversee the management of the Metropolitan Health Service by the CEO;*
- *develop a strategic plan consistent with any guidelines produced by the Minister for Health from time to time;*
- *develop plans, strategies and budgets to ensure the accountable and efficient provision of health services by the Metropolitan Health Service;*
- *develop collaboration arrangements with other health care agencies and health service providers to enable effective and efficient service delivery and continuity of care;*
- *ensure effective and accountable systems are in place to monitor and improve the quality and effectiveness of health services provided by the Metropolitan Health Service;*
- *ensure that any problems identified with the quality or effectiveness of health services are addressed in a timely manner;*
- *monitor the performance of the Metropolitan Health Service and the CEO; and*
- *establish and maintain effective systems to ensure that the health services provided meet the needs of the communities served by the Metropolitan Health Service, and that the views of users of health services are taken into account.*

These proposed statutory provisions are designed to articulate clearly the duties of the board of a Metropolitan Health Service, in particular, the board's responsibility for ensuring the quality of health services provided by the organisation. The board's role in ensuring quality is not currently stated in the Health Services Act in relation to public hospitals or Networks.

In order to supplement the statutory articulation of the roles and responsibilities of boards of governance, it is important that appropriate training and guidance be provided to directors. The Panel considers that a training program and information kit should be developed to assist in educating boards on how to fulfill their statutory duties.

## ***Advisory Committees***

The Review Panel proposes that the legislation should require the board of a Metropolitan Health Service to establish and maintain the following advisory committees:

- ◆ a community advisory committee.

This committee should comprise people who have the capacity to reflect the perspectives of the communities served by the Metropolitan Health Service. Registered health practitioners and people currently employed or engaged in the provision of health services should be ineligible for membership of this committee.

- ◆ a primary care and population health advisory committee.

This committee should comprise people who -

- have expertise in primary health or knowledge of primary health services in the areas which are the particular focus of the Metropolitan Health Service;
- have expertise in identifying health issues affecting the population served by the Metropolitan Health Service and designing strategies to improve the health of that population;
- have knowledge of the health services provided by local government in the areas served by the Metropolitan Health Service.

The legislation should include a positive duty on the board to establish these committees within 6 months of the formation of a Metropolitan Health Service and to ensure that any vacancies are filled within 3 months of the vacancy arising.

Given that different communities will have diverse needs and expectations, it is proposed that the legislation should not dictate limits on the numbers of people on these committees. However, standard guidelines could be developed by DHS to assist the Metropolitan Health Service boards in establishing the committees and formulating procedures to ensure that they function effectively.

The Board should also have the power to establish such other advisory committees as it determines.

These committees could be required to provide an annual report to the board which would be incorporated into the Service's annual report. Subject to any guidelines, the procedures of these committees should be in their discretion.

### **Proposed Recommendation:**

- *The Board should be required to establish a community advisory committee and a primary care and population health advisory committee. The board should have the capacity to establish such other committees as it determines.*

## ***Board Appointments, Remuneration and Immunity***

It is proposed that board appointments be for a maximum of 3 years, or such lesser period specified in the instrument of appointment. Directors should be eligible for re-appointment, but should not be able to serve more than three consecutive terms.

Directors should be entitled to receive such remuneration as is specified in the instrument of appointment and to be reimbursed for reasonable expenses incurred.

While the precise level of remuneration payable to directors is a matter for the Government, the Panel considers that remuneration should be more in the nature of an honorarium rather than the current arrangement for Networks which is more akin to a commercial board. It is proposed to include an immunity against legal action in the legislation, consistent with that currently provided to Networks and public hospitals (rural hospitals).

As is the case for Networks and public hospitals, the legislation should enable the Governor in Council to remove directors or the whole board at any time.

### ***Conflict of Interest***

The Panel considers that the legislation should contain a provision to guide the board on how to manage conflicts of interest.

Where a director has a direct or indirect pecuniary interest in a matter being considered or about to be considered by a board, the legislation should require the director to:-

- declare the interest at a meeting of the board as soon as practicable after the relevant facts come to the director's knowledge;
- absent him or herself during any deliberations of the Board in relation to the matter; and
- not take part in any decision of the board in relation to the matter.

Declarations should be required to be recorded in the minutes of the meeting.

### ***Duties of Directors***

It may be desirable to articulate the key duties applicable to directors/members of boards of public statutory bodies in the Health Services Act. For instance, the legislation could provide that directors must -

- act honestly at all times in the performance of the functions of their office;
- exercise a reasonable degree of care and diligence in the performance of their functions; and
- not make improper use of their position to gain directly or indirectly an advantage for themselves or any other person.

The Panel proposes that any such provision would have effect in addition to all other relevant Acts or laws governing or relevant to the conduct of directors of public statutory bodies.

### ***Machinery issues***

Statutory provisions with respect machinery matters such as the procedure of boards should be similar to those for public hospitals. Similarly, an ongoing provision needs to be made to create and amalgamate Metropolitan Health Services.

## Community Health Centres

In order to enable stand alone community health centres to be re-established quickly to coincide with the establishment of new Metropolitan Health Services, specific 'transitional' provisions could also be inserted into the Health Services Act which enable the creation of new community health centres (CHCs) by Order in Council.

The legislation could deem the CHCs established by Order to have been incorporated under the Associations Incorporation Act and the Orders in Council establishing them could provide for the membership of initial boards, whose appointments are of limited duration. Legislation could also provide that the model rules for incorporated associations under the Associations Incorporation Act comprise the initial rules of the new CHCs and deem these bodies to be registered funded agencies. If necessary, the legislation could also specifically enable the Secretary to vary or add to the model rules, as an interim measure.

Such legislation could make it clear that these are transitional provisions only, pending the shift to boards with elected members, as envisaged by Government policy.

### **Proposed Recommendation:**

- *The legislation should provide for the initial establishment of new stand alone community health centres with appointed boards as an interim measure.*

## Staff

The Panel believes that staff transfer from Networks to new agencies (Metropolitan Health Services or Community Health Centres) may be facilitated by legislation without the need for the overwhelming majority of staff to be offered positions together with all of the uncertainty and anxiety associated with this process.

For instance, legislation could provide for the designation of Network campuses or premises and provide that staff whose principal place of employment was a particular campus immediately before the formation of the new entities or at some other designated date are employed by the 'successor' agency on the same terms and conditions and with the same rights and continuity of service. This proposal envisages that classes of staff or individuals who do not fit this profile would be identified so that they can be made appropriate offers of employment with a new agency.

In the case of staff who work across a number of campuses or across a regional area but are employed by a Network, responsibility for provision of the service may be allocated to one new Metropolitan Health Service or divided among two or more agencies. Where the entire service is transferred to one agency, legislation could facilitate the transfer of staff to the agency on the same terms and conditions and with continuity of service. Where the service is split, existing staff could be offered appropriate positions at one or more of the new agencies, with preservation of their current terms and conditions and with continuity of service.

The Panel proposes that, in the minority of cases where it is not possible to make staff an offer of employment because there is no equivalent position (e.g. some Network head office staff), a redundancy process be followed. The Panel considers that the legislation should

require boards and (if relevant) administrators to use their best endeavours to maximise re-deployment and minimise redundancies.

**Proposed Recommendation:**

- *Legislation should, as far as possible, facilitate the transfer of Network staff to new ‘successor’ health care agencies, on the same terms and conditions and with continuity of service.*

## Trusts

The Review Panel considers that amendments to the Act would be desirable to enable the new Metropolitan Health Services to benefit from any trusts in favour of the former public hospitals which were subsequently aggregated to form health care networks, or trusts in favour of the Health Care Networks, according to the tenor of the trusts.

Amendments to the Health Services Act in 1995 and 1998, enabled health care Networks to be entitled to benefit from trusts in favour of the former public hospitals which the Network succeeded, according to the tenor of the trust concerned.

These provisions only operate in relation to trusts which simply name a former public hospital as a beneficiary or which give the trustee discretion to apply trust funds in favour of a named former public hospital. Where the donor has specified with greater precision the purposes for which trust funds must be applied (e.g. cancer treatment, women’s health etc.), the funds must be applied for the specified purposes. If it is no longer possible to apply the funds for the specified purpose (for instance, because of changes in health care or organisational roles), an application must be made to the Supreme Court for a court order nominating the contemporary purposes for which the trust funds may be used.

In order to ensure that boards apply trust moneys in a manner consistent with the donor’s intention, the Panel recommends that a provision be included in the Health Services Act to the effect that where a trust names a former public hospital and there is a corresponding campus or premises of a Metropolitan Health Service, trust moneys are to be applied so far as is possible, towards services at that campus or those premises. The same principles should also apply in respect of the management of special purpose funds.

If desired, a further qualification could be included to deal with trusts in favour of specialist hospitals. A provision could be included in the legislation to indicate that, where there is no longer a corresponding campus/premises of the new entity and a trust named a former specialist public hospital, trust moneys are to be applied so far as possible for the benefit of services of the kind provided by the former specialist hospital.

**Proposed Recommendation:**

- *Legislation should enable Metropolitan Health Services to benefit from trusts in favour of the former (pre-Network era) public hospitals and require, so far as possible, that trust moneys be applied at the corresponding campus/premises.*

## Health Services Support Agencies

The Review Panel considers that one way of fostering efficiency by minimising expenditure on corporate resources in public health care agencies, is to establish Health Services Support Agencies which can provide centralised corporate services such as finance, information technology, human resources and facilities maintenance to a number of the new Metropolitan Health Services.

The Panel considers that it would be possible to create Health Services Support Agencies either administratively or by legislation as public statutory bodies. Either mechanism would be appropriate, but each has advantages and disadvantages.

The administrative approach could involve establishing a Support agency as an autonomous administrative unit of a Metropolitan Health Service that is funded directly by DHS and managed by a board comprising representatives of those Metropolitan Health Services which use the services of the Support agency.

The principal advantage of establishing the Agencies administratively is that this approach has greater flexibility than legislation. It would allow the concept of Health services support agencies to be trialled, and adjustments made if the arrangements are not working satisfactorily. The legislation should also enable the creation of such Agencies with a statutory basis, where there is agreement for this and a commitment for the Agency to have an ongoing existence.

The Panel is aware that some Support Agency staff will need access to confidential documents to carry out their functions. Staff who are not employed by a Metropolitan Health Service cannot access confidential documents such as identifying patient information without patient consent or specific statutory authority. Legislation would be required to enable the relevant Support Agency staff to access Metropolitan Health Services records for the purposes of carrying out their functions.

### **Proposed Recommendation:**

- *Legislation should facilitate the creation of Health Service Support Agencies.*

## Mental Health Act

It will be necessary to ensure that newly created agencies providing mental health services are appropriately gazetted for the purposes of the Mental Health Act, so that involuntary treatment can lawfully be carried out on the premises. It may be desirable for legislation to enable Orders in Council establishing the new agencies and specifying their premises to deem the appropriate premises to have been gazetted for the purpose of the Mental Health Act.